

FILLED OCT 31 1941  
Registration District No. **19981**

Primary Registration District No. **3011**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Clay *own.*

(b) City or town Excelsior Springs, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Veterans Administration Facility *D*  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days  
(Specify whether *?*)

In this community ?  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan *11*

(c) City or town Wellsville. *0*  
(If outside city or town limits, write "RURAL") *0*

(d) Street No. -- (If rural, give location) *1*

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Andrew A. Markovich

3. (b) If veteran, name war World

3. (c) Social Security No. None

4. Sex Male *0* 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bessie Markovich

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased April 25, 1897  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

44 5 21 hr. min.

9. Birthplace Muncie, Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Osteopath

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Daniel Markovich

13. Birthplace Russia  
(City, town, or county) (State or foreign country)

14. Maiden name Annie Berganzel

15. Birthplace Russia  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital records, Veterans Administration, Excelsior Springs, Mo.

17. (a) Wellsville, Mo. (b) Date thereof 10-16-41  
(Specify residence for removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellsville, Mo.

18. (a) Signature of funeral director Claude Prichard

(b) Address Excelsior Springs, Mo.

19. (a) 10/17/41 (b) Mr. R. M. Cracken  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 16th  
year 1941 hour 8:05 minute A. M.

21. I hereby certify that I attended the deceased from October 6, 1941 to October 16, 1941  
that I last saw him alive on October 16, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Disease of Heart with myocardial fibrosis and myocardial insufficiency

Due to \_\_\_\_\_

Due to \_\_\_\_\_ *131a*

Other conditions Nephritis, chronic, interstitial  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy No autopsy

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature E. A. Welch (M. D. or other) *0*  
Address Veterans Administration Date signed 10-16-41  
Excelsior Springs, Mo.

OCT 30 1944

NOV 18 1944

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Registered Apprentice No. ....

working under my personal supervision.

Signed *Robert Ray*

Licensed Embalmer No. *4152*

P. O. Address *Excelsior Spgs, Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**